

Provider Education

Medicare Part B



Webinar
May 21, 2008
ABN and National and Local Coverage Determinations
Questions & Answers

Contractor General Comment: Please note that the transcript of these questions was edited to allow for the greatest dissemination of information to the widest audience.

The Revised ABN CMS-R-131 Form and Instructions can be found on the CMS website at http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp

Question 1: Does a routine physical include pre-op or is pre-op billable to Medicare?

Answer 1: Routine physicals are generally CPT procedure code 99397 which is statutorily excluded from the Medicare program. Routine physicals are non-covered by Medicare. For information regarding pre-op services, see "Surgical Billing Guide".

Question 2: Please confirm that the term "categorical" is interchangeable or also known as "statutorily" as it relates to exclusions that do not require a waiver.

Answer 2: The terms 'categorically' and 'statutorily excluded' are interchangeable. An ABN is not required on services that are categorically or statutorily excluded but the revised ABN may be used to provide voluntary notification of a patient's financial liability.

Question 3: Is insurance conflict a valid reason for column E? For example, a patient who has a HMO as primary; which we don't accept and Medicare & Blue Cross as secondary; which both think the other is responsible.

Answer 3: Insurance conflicts would not justify using an ABN. ABNs are for service or items that may be denied for medical necessity. If a patient is employed and has a HMO as primary which you do not accept, you should contact the HMO in question to see if you can even render services to the patient and if the patient is financially responsible.

If a patient has a HMO, Medicare and Blue Cross, the patient may be over insured and should evaluate their insurance coverage. Medicare can be secondary to a HMO and may pick up co-payments. Medicare may not pick up out-of-network HMO denials. For Medicare Secondary guidance, please see our Medicare Secondary Guide at <http://www.medicarenhic.com/providers/pubs/mspguide.pdf>
Our Customer Service department can also assist you on matters like this.

Provider Education

Medicare Part B



Question 4: If the font is smaller than 12pt, is the form no longer valid?

Answer 4: The CMS instructions indicate the following:

Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is difficult to fit in the allowed space.)

Question 5: Do ambulance providers use the same ABN form as physicians?

Answer 5: Yes, but only when ABN applies to the ambulance services.

For guidance on when an ABN is required for Ambulance transports, please see our Ambulance Guide at <http://www.medicarenhic.com/providers/pubs/ambguide.pdf>

Question 6: If the service is an excluded service from the program do we have to have the patient fill out an ABN form?

Answer 6: If the service is never covered by Medicare (such as cosmetic surgery) then you do not need to give the patient an ABN. However, the revised ABN may be used to provide voluntary notification of a patient's financial liability.

Question 7: If we issue an ABN as "not medically necessary", but Medicare only considers service experimental, is the ABN no longer valid?

Answer 7: The Notifier should know which services are not medically necessary and what services are experimental. Indicating the incorrect 'Reason Medicare May Not Pay' in section E of the ABN does not necessarily make the ABN invalid.

Question 8: If the patient does not take their copy of the ABN, or if staff forgot to give it to them, can we still bill them?

Answer 8: Yes. It is a recommendation that you provide a copy to the patient. It is a requirement. If the patient forgets to take their copy or staff forgets to give a copy to the patient, mail a copy to their address.

Question 9: Can the reason for the service not being covered be, "Medicare does not cover this service if done by a chiropractor?"

Answer 9: Yes. Except for spinal manipulations, Medicare does not cover other services rendered by chiropractors. An ABN is not required on non-covered services but may be used to provide voluntary notification of a patient's financial liability.

Provider Education

Medicare Part B



Question 10: How do we find LCD for chemotherapy drugs?

Answer 10: LCDs can be found by clicking on “LCDs/PolicyIndices” on the left hand tool bar of our website. There is currently not a LCD for chemotherapy drugs. Coverage of injections is typically based on FDA approval.

Question 11: If we bill for a diagnosis that is listed as covered in the LCD with a KX modifier for physical therapy, why would we receive a denial as not medically necessary?

Answer 11: Just because you are billing a covered diagnosis per the LCD, there are still other requirements needed to cover these services such as if the service was maintenance. Maintenance therapy is not covered as a medical necessity even if it is billed w/ a diagnosis on the LCD.

Question 12: How would we know if the service is considered maintenance?

Answer 12: Physical Therapy Maintenance Programs and Chiropractic Maintenance Therapy are not covered by Medicare. Please view the Physical Therapy and Chiropractic Billing Guides at the following links for additional information on Maintenance Programs and Therapy.

<http://www.medicarenhic.com/providers/pubs/ptotguide.pdf>

<http://www.medicarenhic.com/providers/pubs/chiroguide.pdf>

Question 13: You mentioned that services by immediate relatives are categorically excluded by Medicare. Does this mean that physicians can't see relatives?

Answer 13: Charges imposed by immediate relatives of the patient or members of the patient's household are excluded from coverage. It does not mean that a physician can't render services to a patient. It means that Medicare does not cover services rendered to immediate relatives.

For more information concerning this exclusion, please see Publication 100-02, Chapter 16, Section 130 of the CMS Internet-Only Manual. Chapter 16 can be found on the CMS website at

<http://www.cms.hhs.gov/manuals/Downloads/bp102c16.pdf>

Question 14: We are unsure whether to have our OB/GYN patients sign a waiver for 1) an annual GYN service or just every other year when not covered and 2) an HPV lab screening which is newly recommended by ACOG with the Pap smear?

Answer 14: Use an ABN anytime that you feel the service may be denied by Medicare as not reasonable and medically necessary. You definitely should have a patient sign an ABN when a service is being rendered outside of frequency limits such as with screening pap & pelvic exams.

In order to determine if you need to use an ABN for HPV lab screening, you would have to first determine if the service is covered by Medicare. HPV vaccines (CPT code 90649) are not currently covered under the Medicare program as a preventive service.

Provider Education

Medicare Part B



Question 15: If a physician has a CLIA license, why do we get denials for urinalysis by dip stick?

Answer 15: If you are receiving a CLIA denial, it most likely relates to the level of certificate the physician has. Urinalysis CPT code 81002 is a waived lab service which requires a waiver certificate. CPT code 81000 requires a higher level of certificate for Provider Performed Microscopy Procedures. Please contact our Customer Service department for more information on your specific denials

Question 16: Medicare does not cover X-rays ordered by a Chiropractor. Should we use the NEMB or the ABN, for services rendered?

Answer 16: The NEMB is incorporated in the revised ABN. There is no longer a separate NEMB notice. The revised ABN may be used to provide voluntary notification of a patient's financial liability such as for the services that are performed by chiropractors that are not covered by Medicare..

Question 17: What is NEMB?

Answer 17: The revised ABN (CMS-R-131) combines the prior general ABN (ABN-G), the laboratory ABN (ABN-L) and the Notice of Exclusion of Medicare Benefits (NEMB) into a single notice.

Question 18: If a box is not checked, is the form still valid?

Answer 18: Probably not. The ABN is only effective for the boxes or field clearly marked on the notice at the time it is signed by the beneficiary or representative.

Question 19: When a patient has met the physical therapy CAP do we have them sign an ABN or NEMB?

Answer 19: The new ABN includes the NEMB. If patient has met CAP and KX does not apply, the services over the CAP are considered non covered and thus no ABN is required. However, as stated earlier, it can be used for voluntary notification of a patient's financial responsibility.

Question 20: If a GY modifier is used for a service we know is not payable by Medicare (no ABN signed), and the secondary insurance says it's patient responsibility, can we then assign it to the patient?

Answer 20: If the service is not a Medicare benefit and you need a denial for the patient's secondary insurance, then please bill with a GY modifier. If the secondary decides to pay nothing at that point, then the patient is fully responsible.

Provider Education

Medicare Part B



Question 21: If a patient is having a routine annual pap smear and the specimen is being sent to an outside lab to be processed, do we need to have the patient sign an ABN?

Answer 21: Pap and pelvic exams have frequency limits so an ABN may apply. If specimen is sent to an outside lab, you are responsible for getting ABN on behalf of lab since you are seeing the patient.

Question 22: Do we have to issue the patient an NEMB to bill them for a non covered service?
Ex: If the patient has a routine exam do we have to issue one to bill them?

Answer 22: The regulations do not require a NEMB or ABN to be given for non covered services. The new ABN can be used to communicate to the patient their financial liability. If you need a denial bill with a GY modifier..

Question 23: If x-rays ordered by chiropractors are not covered and no ABN is needed then why are we denied saying we can't bill the patient?

Answer 23: Make sure you are billing with the proper GY modifier.

Question 24: In regards to obtaining an ABN for labs on patients that are residents of a SNF, what should be done for testing that is not going to be covered? Who should be signing the ABN? Labs are generally drawn at 5:00am or thereabouts. Should the facility be signing the ABN?

Answer 24: The patient should sign if they are able. If the facility knows that a lab drawing is going to occur, the ABN can be signed in advance. If the patient is unable to sign, someone can sign on their behalf.

Question 25: What if patient doesn't come to office until after extensive preparation such as is needed for virtual colonography?

Answer 25: If your office feels the service may be denied by the Medicare program for medical necessity, then you may want to issue the patient an ABN prior to giving the patient that specific item or service

Question 26: If a patient comes in for treatment for the first evaluation (when it comes for the witness signing for them) and they refuse to sign the ABN form, do we have to indicate on the form that they refuse to sign the ABN form?

Answer 26: Yes, you will be able to document on the ABN on Item H that you had someone witness it (but make sure that witness does not have any "Conflict of Interest"). It will be someone from the waiting room, or someone that came in with the patient. It cannot be someone from your office because of conflict of interest. This only applies for Assigned claims. For Unassigned claims, the patients have to sign.

Provider Education

Medicare Part B



Question 27: We offer a drug “Avastin” for off label use, could we use it for a different diagnosis than the FDA approved, but there is no LCD coverage of it and we worry because Medicare is not going to pay. Through our experience, Medicare does pay it; but we still worry that once they do a Medicare Review at some point, maybe, then they may retroactively deny it.

Answer 27: For your own protection, an Advanced Beneficiary Notice would be appropriate in that instance. Most of the time, you’ll find with oncology drugs though, on off label uses, we do confer them with the general census on what’s going on in the medical community at that time if this drug is routinely used for that diagnosis. More than likely, it’s going to have coverage under that program. Should we at any time decide not to cover for a particular reason, obviously, your association and your physician could submit documentation showing us the validity of the use of that drug for that condition.

Question 28: When it comes to the ABN on the “D” portion, (we’re a radiology group) do we have to list every exam or can we just put “all exams”?

Answer 28: What you need to do on the ABN is to list specifically each exam or service that you anticipate a denial. Let’s say that you are doing a chest x-ray, or an ultrasound and if a policy exists for a chest x-ray but doesn’t exist for the ultrasound, you will just list the chest x-ray on the ABN. Now, if the policy exists for every tests that you are doing on that day, yes, by all means, you have to list each specific test, the reason each specific test would be denied and the estimated costs for each specific tests separately. It is not legal to have an ABN with information that says “all the tests”.

Would it be of benefit to include the GZ modifier?

GZ means that you were supposed to get an ABN but you forgot to get an ABN. This is a right code to use if you want to bill correctly, but it’s not a benefit as far as payment goes.

Question 29: We often do IV treatment in our office but we consider it not medically necessary in someone with a cold or the flu. Our doctor may prescribe intravenous vitamin C and I would think that’s not considered medically necessary. So every time someone has prescribed that, I’m getting an ABN. Should I be getting an ABN or Notice of Exclusion of Medicare (NEMB) benefits because that would be considered more like a comfort item.

Answer 29: There is not going to be a “Notice of Exclusion” in the future, the form is being “retired”. The ABN will be used for both non-coverage services and medical necessity and frequency denials. The vitamin C infusion is a non-coverage service. So you could use an ABN but when you get to the box of the ABN where you are explaining why (Box E), just put a note that it is a “Non-coverage” service. Then give them an estimate of cost, get the money up front before you do the service (I would recommend) and what they need to sign is Option 2.

Is it specific enough to put “Laboratory Services” on the ABN?

No, it has to be very specific. You need to look, though, if the service that you’re rendering like the Lipid panel and you’re doing it for a covered reason, then an ABN is not necessary. It is only when you’re doing a Lipid Panel and you don’t see any ICD-9 code on the list of covered reason, then you would need an ABN.

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